Ultimate Dental Care

Welcome To Our Practice

Patient Information

Date _____

☐ Male ☐ Female ☐ Minor

☐ Single ☐ Married ☐ Divorced

Name _____

Address _____

City, State, Zip _____

Date of Birth _____ Social Security _____ Email _____

At which number do you prefer to be contacted at (check below) Can you be called at work? ☐ Yes ☐ No

☐ Home Phone _____ ☐ Cell _____ ☐ Work _____

Employer _____ Department _____

Person to Contact in Case of Emergency _____ Relationship _____

Home Phone _____ Cell Phone _____ Work _____

Parent or Spouse's Name _____

Address _____ Phone _____

How Did You Hear About Us? _____

Dental Insurance Information

Name of Primary Insured _____ Relationship to Patient _____

Date of Birth of Insured _____ Social Security # of Insured _____

Employer _____

Address of Employer _____ Phone _____

Name of Dental Insurance Co. _____

Group Number _____ ID Number _____

Insurance Phone Number _____

Is there a Secondary Dental Insurance? ☐ Yes ☐ No

If so, please complete the following information:

Name of Primary Insured _____ Relationship to Patient _____

Date of Birth of Insured _____ Social Security # of Insured _____

Employer _____

Address of Employer _____ Phone _____

Name of Dental Insurance Co. _____

Group Number _____ ID Number _____

Insurance Phone Number _____

Responsible Party

Person Responsible for this Account _____

Social Security Number _____

Relationship to Patient _____

Address _____

Home Phone _____ Cell _____ Work _____

Employer _____